Instructions for Completing HCFA Forms 485, 487 and 486

The HCFA-485, Home Health Certification and Plan of Treatment, is a plan of care (POC) which can be completed for Wisconsin Medicaid recipients receiving personal care worker (PCW) services. The HCFA-487, Addendum to the Plan of Treatment/Medical Update and Patient Information, may be used to provide additional documentation of any elements on the HCFA-485 or the HCFA-486, which is an update of the HCFA-485.

These forms are national forms which are available from your Medicare carrier. These forms are not available from the Wisconsin Medicaid fiscal agent. When you complete these forms to provide information to Medicare for a client who is eligible for both Medicare and Medicaid, you may submit a copy of the completed forms to Medicaid, subject to the adjustments listed below. When you use these forms for non-Medicare clients, you may:

*   Use forms obtained from the Medicare intermediary and declare them on your Medicare cost report.
*   Copy or print your own supply of the forms.
*   Purchase the forms from another source.

HCFA-485

Item 1: Patient's Health Insurance (HI) Claim Number
Enter the recipient's 10-digit Medicaid identification number as found on the recipient's Forward identification card.

Item 2: Start of Care Date
Enter the six-digit month, day, year on which covered services began, i.e., MM/DD/YY (e.g., 06/15/99). The start of care date is the first billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged.

Item 3: Certification Period (optional)
Enter the two-digit month, day, year, MM/DD/YY (e.g., 06/15/99 - 08/15/99), which identifies the period covered by the physician's POC. The "FROM" date for the initial certification is required to match the start of care date. The "TO" date can be up to, but never more than, two calendar months later and mathematically never more than 62 days. Always repeat the "TO" date on a subsequent recertification as the next sequential "FROM" date. Services delivered on the "TO" date are covered in the next certification period.

> *Example:*   Initial certification "FROM" date 06/15/99
>   Initial certification "TO" date 08/15/99
>
>   Recertification "FROM" date 08/15/99
>   Recertification "TO" date 10/15/99

Item 4: Medical Record Number (not required)

Item 5: Provider Number
Enter the eight-digit Medicaid provider number of the billing provider.

Item 6: Patient's Name and Address
Enter the recipient's name exactly as it appears on the recipient's Forward identification card. Enter the address of the recipient's place of residence; the street, city, state, and ZIP code must be included.

Item 7: Provider's Name, Address and Telephone Number
Enter the name, complete address (street, city, state, and ZIP code), and telephone number of the billing provider.

Item 8: Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., February 3, 1955 would be 02/03/55).

Item 9: Sex
Enter an "X" to specify male or female.

Item 10: Medications
Enter all physician's orders for all medications, including the dosage, frequency and route of administration for each. Use the addendum HCFA-487 for drugs which cannot be listed on the plan of treatment. Even when a personal care worker (PCW) is not administering the medication, he or she will need to know the medications, actions, side effects, etc.

Item 11: ICD-9-CM, Principal Diagnosis, Date
Enter the principal diagnosis code, using the appropriate *International Classification of Diseases, 9th Edition, Clinical Modification* (ICD-9-CM) diagnosis code, description, and the date (in MM/DD/YY format) of onset of the medical reason for home health care services. If a condition is chronic or long term in nature, use the date of exacerbation.

Item 12: ICD-9-CM, Surgical Procedure, Date
Enter the surgical procedure relevant to the care rendered. For example, if the diagnosis in Item 11 is "Fractured Left Hip," note the ICD-9-CM code, the surgical procedure, and date (e.g., 81.62, Insertion of Austin Moore Prosthesis, 06/09/99). If a surgical procedure was not performed or is not relevant to the POC, do not leave the box blank, enter N/A. Use the addendum (HCFA-487) for additional relevant surgical procedures. At a minimum, the month and year is required to be present for the date of surgery. Use 00 if the day is unknown.

Item 13: ICD-9-CM, Other Pertinent Diagnoses, Date
Enter all pertinent diagnoses, both narrative and ICD-9-CM codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the POC was established or which developed subsequently. Exclude diagnoses that relate to an earlier episode which have no bearing on this POC. These diagnoses can be changed to reflect changes in the patient's condition.

Item 14: Durable Medical Equipment and Supplies
Enter all nonroutine supplies which you are supplying to the recipient.

For example, dressing changes may require use of 4 x 4s, telfa pads, kling and non-allergic tape. Catheter changes may require catheter kit and an irrigation kit as well as irrigating solutions. You need not list the exact amount of usage.

Note the item(s) of Durable Medical Equipment (DME) ordered by the physician that will be billed to Medicaid.

Enter "N/A" if no supplies or DME will be billed.

Item 15: Safety Measures
Enter the physician's instructions for safety measures.

Item 16: Nutritional Requirements

Enter the physician's order for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Record fluid needs or restrictions. Total Parenteral Nutrition (TPN) can be listed, and if more room is needed, place additional information under medications. If more space is necessary, use the HCFA-487.

Item 17: Allergies

Enter modifications to which the patient is allergic and other allergies the patient experiences (e.g., foods, adhesive tape, Iodine, etc.). "No known allergies" may be an appropriate response.

Item 18a: Functional Limitations

Check all items which describe the patient's current limitations as assessed by the physician and you.

Item 18b: Activities Permitted

Check the activity(ies) which the physician allows for and/or which physician orders are present.

If you check "Other" under either the "Functional Limitations" or "Activities Permitted" category, provide a narrative explanation in Item 8 of the HCFA-487.

Item 19: Mental Status

Check the block(s) most appropriate to describe the patient's mental status. If you check "Other," specify the conditions.

Item 20: Prognosis

Check the box which specifies the most appropriate prognosis for the patient: poor, guarded, fair, good, or excellent.

Item 21: Orders for Discipline and Treatments

Specify the frequency and the expected duration of the visits for each discipline ordered. State the duties/treatments to be performed by each. A discipline may be one or more of the following: registered nurse (RN), licensed practical nurse (LPN), physical therapy (PT), speech therapy (ST), occupational therapy (OT), medical social service (MSS), home health aide (AIDE), or others (e.g., nutritionist, male orderly, respiratory therapist).

Orders must include all disciplines and treatments, even if they are not billable to Medicaid.

Frequency denotes the length of the visits, and the number of visits per discipline to be rendered, stated in days, weeks, or months. Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks, or months.

PRN ("as needed") visits may be ordered on a POC only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service is required to be specified. Open-ended, unqualified PRN visits do not constitute physician orders since neither their nature nor their frequency is specified.

Item 22: Goals, Rehabilitation Potential, Discharge Plans

Enter information which reflects the physician's description of the achievable goals and the patient's ability to meet them, as well as plans for care after discharge.

Rehabilitation potential addresses the patient's ability to attain his or her goals and an estimate of the time needed to achieve them. This information is pertinent to the nature of the patient's condition and ability to respond. The words "Fair" or "Poor" alone are not acceptable. Add descriptors.

Appendix

Item 23: Nurse's Signature and Date of Verbal Start of Care Where Applicable

This verifies that a nurse spoke to the attending physician and received verbal authorization to visit the patient.

The item is signed and dated by the nurse receiving the verbal orders. Document the initial and ongoing communications with the physician.

Enter "N/A" if the physician has signed and dated the HCFA-485 on or before the start of care date.

Item 24: Physician's Name and Address

Print the physician's name and address. The attending physician is the physician who established the POC and who certifies and recertifies the medical necessity of the visits and/or services. Mention supplemental physicians involved in a patient's care only in Item 8 of the HCFA-487.

Item 25: Date HHA Received, Signed POC/POT

Enter the date you received the signed POC/POT from the attending/referring physician.

Item 26: Physician Certification

This statement serves to verify that the physician has reviewed the POC and certifies the need for the services. Cross out areas that do not apply.

Item 27: Attending Physician's Signature, Date Signed

The attending physician signs and dates the POC within 20 working days following the start of care. Rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending physician to care for his patient in his absence.

Do not predate the orders for the physician, nor write the date in the field. If the physician left it blank, enter the date you received the signed POC under Item 25. Do not enter "N/A." Retain the signed POC and submit a copy with any prior authorization requests.

HCFA-487

Item 1: Patient's Health Insurance (HI) Claim Number

Enter the recipient's 10-digit Medicaid identification number as found on the recipient's Forward identification card.

Item 2: Start of Care Date

For dually eligible recipients, enter the Medicare start of care date. For Medicaid recipients who are not also eligible for Medicare, enter the date of the first Medicaid billable visit.

Item 3: Certification Period

Enter the two-digit month, day, year, MM/DD/YY (e.g., 06/15/99 - 08/15/99), which identifies the period covered by the physician's POC. The "FROM" date for the initial certification is required to match the start of care date. The "TO" date can be up to, but never more than, two calendar months later and mathematically never more than 62 days. Always repeat the "TO" date on a subsequent recertification as the next sequential "FROM" date. Services delivered on the "TO" date are covered in the next certification period.

Example: Initial certification "FROM" date 06/15/99
Initial certification "TO" date 08/15/99

Recertification "FROM" date 08/15/99
Recertification "TO" date 10/15/99

Appendix

Item 4: Medical Record Number (not required)

Item 5: Provider Number

Enter the eight-digit Medicaid provider number of the billing provider.

Item 6: Patient's Name

Enter the recipient's name exactly as it appears on the recipient's Forward identification card. Enter the address of the recipient's place of residence; the street, city, state, and ZIP code must be included.

Item 7: Provider's Name

Enter the name and complete address (street, city, state, and ZIP code) of the billing provider.

Item 8: Item Number (not required)

List item numbers from the corresponding HCFA 485 for those items where additional space is needed.

Items 9/10: Signature of Physician and Date

If the physician's signature is not entered, the registered nurse who has accepted the verbal orders is required to sign and date the form at Items 11/12. The signed HCFA-487 must be placed in the recipient's file within 20 days of the verbal order. Services provided without properly documented physician orders are subject to recoupment.

Items 11/12: Optional Name/Signature of Nurse/Therapist and Date

The registered nurse accepting verbal orders is required to sign and date here.

HCFA-486

Item 1: Patient's Health Insurance (HI) Claim Number

Enter the recipient's 10-digit Medicaid identification number as found on the recipient's Forward identification card.

Item 2: Start of Care Date

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Item 3: Certification Period (optional)

Enter the two-digit month, day, year, MM/DD/YY (e.g., 06/15/99 - 08/15/99), which identifies the period covered by the physician's POC. The "FROM" date for the initial certification is required to match the start of care date. The "TO" date can be up to, but never more than, two calendar months later and mathematically never more than 62 days. Always repeat the "TO" date on a subsequent recertification as the next sequential "FROM" date. Services delivered on the "TO" date are covered in the next certification period.

    Example: Initial certification "FROM" date 06/15/99
                      Initial certification "TO" date 08/15/99

                      Recertification "FROM" date 08/15/99
                      Recertification "TO" date 10/15/99

Item 4: Medical Record Number (not required)

Item 5: Provider Number

Enter the eight-digit Medicaid provider number of the billing provider.

Appendix

Item 6: Patient's Name and Address
Enter the recipient's name exactly as it appears on the recipient's Forward identification card.

Item 7: Provider's Name
Enter the name of the billing provider.

Item 8: Medicare Covered (not required)

Item 9: Date Physician Last Saw Patient
Enter the date the physician last saw the patient, if this information can be obtained during the home visit. If you are unable to determine this date, enter "Unknown."

Note: It is not intended that you contact the physician's office to account for patient's visits. It is expected, but not required, for coverage that the physician who signed the POC will see the patient. However, there is no specified interval of time within which the patient is expected to be seen. Your intermediary evaluates the patient's medical condition. Visits are not denied solely on the basis that the physician does not see the patient.

Item 10: Date Last Contacted Physician
Note the month, day, and year (MM/DD/YY e.g., 12/10/99) of your most recent physician contact (verbal or written) regarding the status or problems encountered with the patient during the last 60 days. Briefly state the purpose of your contact under Item 15 (Updated Information).

Item 11: Is Patient Receiving Care in a 1861 (J) (1) Skilled Nursing Facility or Equivalent
Check the appropriate block. Since a requirement for eligibility for the home health benefit is that services be provided at the patient's residence, if the patient is residing in a nursing home, the facility cannot be considered the patient's residence.

Item 12: Certification/Recertification/Modified
Check one of the blocks to identify this POC as a certification, recertification, or modification. Modified refers to the HCFA-486 used to report changes during a certification period.

Item 13: Dates of Last Inpatient Stay
Enter the admission and discharge dates (MM/DD/YY e.g., 10/02/99 - 10/12/99) of the last inpatient stay relevant to the care provided. Enter "N/A" if not applicable.

Item 14: Type of Facility
Identify the type of facility. If Item 13 has been completed, recording a stay relevant to care being provided, this item must also be completed. Enter "N/A" if not applicable.

The responses for the locator are:

    A = Acute Hospital
    S = SNF
    R = Rehabilitation Hospital
    I = ICF
    O = Other
    U = Unknown

Appendix

Item 15: Updated Information (New Orders/Treatments/Clinical Facts/Summary From Each Discipline)

Record any new orders, treatments or changes and associated date(s) from the time the HCFA-485 is completed, to the time the HCFA-486 is completed.

On certifications, enter the clinical findings of the initial assessment visit for all disciplines involved in the care plan. Describe the clinical facts about the patient that require skilled home health services. Include specific dates.

On recertification, record significant clinical findings for each discipline incorporating all symptoms and changes in the patient's condition during the last 60 days of service. Include specific dates. Document progress or nonprogress for each discipline.

Include any pertinent information on a patient's inpatient stay and the purpose of any agency contact with the physicians, if applicable.

Item 16: Functional Limitations (Expand from HCFA-485 and Level of ADL) Reason Homebound/ Prior Functional Status

Provide a narrative description of the patient's prior functional status and current limitations and activities permitted. Elaborate on the information in the checklist (HCFA-485 Items 18a and 18b) and provide any other information needed to describe the patient. Clearly reflect the type and scope of assistance needed. Include a brief statement of why the patient is homebound. Include a description of the home environment if it is relevant to the homebound determination (e.g., patient lives in a third floor walk-up apartment and is recovering from congestive heart failure).

Item 17: Supplementary POC on File From Physician Other Than the Referring Physician (If yes, Specify Giving Goals/Rehabilitation Potential/Discharge Plan)

Provide this information if more than one POC is being used to provide services. If so, document the specialty, type of service, duties, goals, rehabilitation potential, and discharge plans here or attach a copy of the written plan to the HCFA-486. Give the reasons necessitating a supplemental plan.

Item 18: Unusual Home/Social Environment

Use this block to include information which enhances the reviewer's concept of the home situation and helps to justify the need for services in the home (e.g., patient lives with retarded son, who is unable to provide any assistance or to comprehend instructions). The information may explain the rationale for medical social services by documenting the problems which are, or will be, an impediment to the effective treatment of the patient's medical condition or rate of recovery.

Item 19: Indicate Any Time You Made a Visit and Patient was not Home, and Reasons Why Patient was Gone, if Ascertainable

Indicate when and why this occurred (e.g., 11/03/99 - patient was taken to the emergency room for evaluation and treatment after a fall at home).

Item 20: Specify Any Known Medical and/or Nonmedical Reasons Why the Patient Regularly Leaves Home and Frequency of Occurence

Obtain information from the patient, family or caretaker for the patient's absences from the home and whether they were for medical or nonmedical reasons (e.g., the patient goes to the barber shop once a month and to the doctor twice a month).

Item 21: Signature of Nurse of Therapist Completing or Reviewing Form/Date (Month, Day, Year)

The nurse or therapist responsible for the completion of the form, or a nonclerical agency representative or supervisor responsible for the review, signs and dates the form.

Appendix